

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-014199

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 495

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

15117

125117

3

4 1

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF *H.C. Senne, M.D.* MEDICAL CERTIFICATION

1. **FILED MAY 7 1962**
 a. COUNTY Buchanan

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 50 yrs

c. CITY OR TOWN St. Joseph Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Methodist Hospital Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 2423 So. 17th St. Residence on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
NELLIE ELIZABETH BYRNE

4. DATE OF DEATH Month Day Year
April 28 1962

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 7/12/1883 9. AGE (last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) Kellerton Iowa 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Jess Kirkbride 13b. MOTHER'S MAIDEN NAME Mary Ramsey 14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address Mrs. Nellie Stafford St. Joseph, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cerebro-Vascular Accident
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebro-arteriosclerosis
 DUE TO (c) _____
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
 PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
 a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-26-62 to 4-28-62 and last saw Deceased live on 4-27-62
 Death occurred at 6:50A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H.C. Senne M.D. 22b. ADDRESS 223 N 7th St. Joseph Mo. 22c. DATE SIGNED 4-30-62

23a. BURIAL, CREMATION, REMOVAL FROM COUNTRY Burial 23b. DATE May 1, 1962 23c. NAME OF CEMETERY OR CREMATORY Ashland Mausoleum 23d. LOCATION (City, town, or county) (State) St. Joseph Missouri

24. FUNERAL DIRECTOR Stamper Funeral Home N.A.S. ADDRESS St. Joseph, Mo. 25. DATE RECD. BY LOCAL REG. May 3 1962 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.